Nemours. Children's Health System

Mental Health America

Core Elements of an Accountable Community for Health for Children and Families

Overview: *Defining an Accountable Community for Health for Children and Families*

Adopted from "Defining an Accountable Community for Health for Children and Families[1]" October 2017 National Academy of Medicine Discussion Paper by Daniella Gratale and Debbie Chang

Why Accountable Communities for Health for Children and Families?

Mounting evidence shows the importance of early developmental years in shaping an individual's long-term health trajectory. Therefore, it is critical to address social determinants early on. Leading thinkers have posited that forging structured collaborations among multisector community partners who share goals and resources is critical to "moving health care upstream." Accountable Communities for Health (ACH) are structured collaborations among health care, public health, and other partners (such as schools or community-based human service agencies) that work to improve health, safety, and equity within a defined geographic area through comprehensive, coordinated strategies.[2]

What is an Accountable Community for Health for Children and Families (ACHCF)?

Accountable Communities for Health for Children and Families (ACHCF) aim to help children (prenatal to age 21, perhaps up to age 26 for special needs populations) and families thrive by focusing on optimizing health, improving quality, and reducing the total cost of care for a population over time. ACHCF recognize whole person care is critical, and take a life course approach to advancing health and wellbeing. An ACHCF model necessitates a community coming together around shared health goals and working towards an arrangement in which they are all held financially accountable and jointly responsible for achieving shared goals and metrics across sectors, with an integrator entity or entities serving as the glue that binds the initiative. The core of this model is creating sustainable systems and structures that support community members in addressing health-related needs in a community to improve the health of the population. While the initial focus may be on a particular health issue or condition, over time, an ACHCF should work to identify and address health-related social needs for the child and family (e.g., housing, food security, education, economic stability, and so on), create stronger connections among key sectors (including education and social services) to support a more efficient "community care coordination system," where the needs that are identified are addressed through existing community resources, and fill in gaps where there is no provider or service to address needs. The ACHCF should also recognize that not all children live in families, and also work to improve the health and wellbeing of vulnerable youth – those in foster care, the homeless, and others – and nurture the development of social support for all community members.

Core Elements of an ACHCF

The following recommended elements represent a mix of features that are included in a paper describing the key roles of an integrator[3], existing ACH models and descriptions (e.g., the California Accountable Communities for Health Initiative[4], the Prevention Institute's paper[5]) or Accountable Health

Communities models (e.g., the Innovation Center), in addition to elements added as a result of a November 1, 2016, Nemours–Aspen Institute convening and subsequent calls.

1. **Shared vision and addressing gaps:** Acknowledging that it takes time to build trust and respect, partners (including community participants) would agree upon a shared vision and goals to optimize health and promote equity for children and families, including a plan for addressing unmet needs. The shared vision would encourage compatible and synergistic actions amongst partners and embrace a whole child, life course approach to achieving outcomes. Specific outcomes and expected impact would be discussed in language that is mutually understood across sectors and by community members.
2. **Integrator/backbone/bridge organization to connect multisector partners**: An agreed-upon entity or entities would serve as a neutral convener, working intentionally and systematically across sectors to improve health and well-being for a geographically based target population. The integrator, which could be catalyzed through an initial investment of financing or resources, would identify existing interventions in a community, analyze the evidence base, assess gaps and work closely with a community leadership team to advise on the development and management of a cross-sector financial sustainability mechanism to pool funds and reinvest the shared savings. The integrator could identify entities with which it would contract to provide a portfolio of interventions and invest to build community capacity to provide services that are not currently available but are needed, or this function could be performed by the leadership team.
3. **Trusted community leadership and governance**: Communities would identify trusted champions and develop a governance structure that describes the decision-making process and articulates key roles and responsibilities. Families, young adults, and youth advocates would play key roles in the governance structures, and the integrator or community leadership team could intentionally work to build the capacity, support or conditions for families to successfully participate, maximizing equitable participation and community voice in governance. The leadership team would coordinate closely with the integrator.
4. **Two-generation approaches:** Communities would develop strategies aimed at improving the health of children (prenatal to age 21, with the potential to go to age 26 for special needs populations) and their primary caregivers, with special attention paid to promoting health equity and addressing health disparities.
5. **Population and patient-level metrics and outcomes to achieve a shared community goal:** Building on the IOM report Vital Signs: Core Metrics for Health and Health Care Progress and evolving work to develop pediatric core metrics, communities would select a set of short-term metrics, intermediate metrics with long-term implications, as well as long-term metrics with spillover effects in various sectors, and would be held jointly accountable for achieving progress at the patient and population level within a geographic area, which could include a total cost-of-care metric.
6. **Data analytics, evaluation and communications/data-sharing:** A well-functioning ACHCF necessitates strong data, analytics, and IT infrastructure to measure progress and guide future work. To share learnings within the ACHCF, communities would develop a system of ongoing and intentional communication and feedback among partners and community residents, as well as data-sharing agreements. The voice of the family would be amplified through interoperable communications structures. The feedback loop created would inform how resources are allocated (e.g., when referrals for service are made but there is no community provider that can

fill the need) and what federal, state, or local barriers (such as FERPA, HIPAA, and 42 CFR Part 2) are hindering progress.

7. **Community Care Coordination System:** A community care coordination system would help ensure that individuals are referred to and obtain the educational, medical, behavioral, and social services they need across sectors with minimal duplication, including ensuring that the referring provider/entity is notified when services are provided. The system would ideally be community-wide with a "no wrong door policy" so that a community organization from one sector could refer an individual to a service provider in another sector. As part of a broader community care coordination system, a closed loop technology system could assist communities in assessing the needs of community members, making connections to and assessing the quality of existing services, and identifying gaps.
8. **Key Portfolio of Interventions:** Communities would perform (or use an existing) needs assessment/ community resource inventory; identify, educate, support, refer, and treat participants through fluid screening (including using developmental and social determinants screening tools) and early intervention strategies based on risk stratification; develop and implement prevention strategies; and incorporate team-based health care approaches to reduce cost and utilization. This would include a mix of interventions at the individual, community and systems level, with navigation systems built in where relevant. Inclusion of family-centered medical homes and development of integrated primary care models (e.g. pediatrics with child development, social work, and/or behavioral health professionals embedded as part of the primary care team) would ensure best practices, gain needed buy-in from healthcare partners, facilitate early cross-sector communication wins, and leverage traditional and evolving healthcare financing for quantifiable, short term cost savings. The portfolio of interventions should also align with or leverage other existing service delivery systems.
9. **Value-based payment**: Early on in the initiative, a glide path to value-based payment with one or more funders, public systems, health care payers, managed care organizations, and providers should be considered given that all parties would have aligned incentives related to cost, quality, and health outcomes. This may take years to develop, but initial conversations and alignment of goals and community needs assessments could be important first steps. Value for the ACHCF should be defined, and collaboration should be incentivized. It could include paying for specific outcomes or performance through public programs and clinical payment (rooted in primary care) as well incentive payments for community partners. Communities would link the data they collect, the metrics they are seeking to achieve, and the value-based payment model that rewards progress toward achieving the outcomes they set forth. States can play a major role in setting a policy context favorable to advancing value-based payment models that help address social determinants of health.
10. **Financial sustainability:** While many ACHCF come to fruition under some start-up financial support (such as in-kind contributions, federal, state, or private grant money, and others), communities would develop and implement a sustainable plan for securing resources to support the goals, priorities, and strategies developed by the ACHCF. The integrator can facilitate a sustainability business case to identify potential investors linked to the portfolio of interventions and advise the leadership team in setting up appropriate financial sustainability mechanisms to braid existing funding as well as blend new investment. The goal would be the creation of a structure to accept investment, shared savings and incentives across sectors to promote joint financial accountability in pursuit of the community's overarching goals and metrics.

Additional Features of an ACHCF Initiative

In addition to the above core elements which would be characteristic of an ACHCF, the following two elements could be investments that a funder would want to make to share learnings across sites for an ACHCF initiative that includes multiple communities.

1. **Technical Assistance (TA) Center:** A centralized TA Center would help communities develop approaches and agreements for collecting, analyzing, and sharing financial, community, and population-level data across a variety of providers and organizations needed to advance common goals. In compliance with existing laws governing protected health information and student education records (e.g., the Health Insurance Portability and Accountability Act, Family Education Rights and Privacy Act) and other relevant laws, sharing of data publicly and with community partners would occur and would be used to drive change through empirically informed decision aids. The TA Center would assist in sharing best practices, guidelines, and memoranda of understanding currently used to promote data sharing, identify barriers, and develop proposed solutions, as needed. Additionally, independent evaluators would assess progress toward achieving the goals set forth. If communities had a strong rationale for altering their metrics during the course of the award, flexibility would be granted.
2. **Learning Systems and Communications:** To support continuous improvement, learning and communication would occur across sites. This could occur formally through calls, listservs or convenings organized by the TA Center and informally among awardees of an ACHCF initiative. Cross-fertilization opportunities that enable communities to learn from other existing ACH initiatives should also be encouraged.

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[1] Gratale, D., and D. Chang. 2017. Defining an Accountable Community for Health for Children and Families. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/Defining-an-accountable-community-for-health-for-children-and-families.

[2] Mikkelsen L., W. L. Haar, L. J. Estes, and V. Nichols. 2016. The Accountable Community for Health: A model for the next phase of health system transformation. Prevention Institute. https://www.preventioninstitute.org/publications/accountable-community-health-emerging-model-health-system-transformation.

[3] 2012. Integrator role and functions in population health improvement initiatives, http://www.improvingpopulationhealth.org/Integrator%20role%20and%20functions_FINAL.pdf.

[4] Community Partners. 2016. California Accountable Communities for Health Initiative Request for Proposals, http://www.communitypartners.org/sites/default/files/documents/cachi/rfp/CACHI%20RFP%20Updated%204-6-16.pdf.

[5] Mikkelsen L., W. L. Haar, L. J. Estes, and V. Nichols. 2016.